Chapter 2
How to Implement Quality Improvement in Opioid Agonist Therapy Clinics Using the OMS

The OMS is a toolkit consisting of methods for collecting baseline data on clinic practices and outcomes, methods for comparing baseline practice data to best-practice recommendations to identify potential areas for quality improvement (QI), and educational materials and tools to support identified QI goals.

Step 1: The Baseline Assessment:

The first step toward implementing QI efforts is to collect baseline data regarding current clinic practices and outcomes. The centerpiece of the OMS is the *Case Management Log,* which permits a simple and quick method for case managers to collect baseline and monthly data on their current practices and their patient outcomes (e.g., dose of agonist, counseling visits/month, urine screen results). See Chapter 6, Materials and Forms, for an example of the *Case Management Log.* The OMS contains a step-by-step procedure for developing feedback graphs based on the *Case Management Log*. Feedback graphs for clinic leaders allow them to view each case manager's current performance and outcomes relative to summary data for the entire clinic. Feedback graphs for individual case managers allow them to compare their own practices and outcomes to summary data for the entire clinic.

In addition, tools for baseline data collection include the *Abstinence Orientation Scale* (Caplehorn et al., 1998). The *Abstinence Orientation Scale* is a 14-item scale that requires clinic staff to rate their agreement with statements reflective of a detoxification orientation (e.g., methadone maintenance patients who continue to use illicit opiates should have their dose of methadone reduced). Each scale item has five responses that are assigned a value of one to five points. An individual's score is calculated by determining their mean item score. Individuals' mean scores can be used to determine the average score for the clinic. Scores of 3 or greater suggest strong abstinence oriented beliefs. See Chapter 6, Forms and Materials, for a copy of *The Abstinence Orientation Scale.*

In completing a baseline clinic assessment, it is recommended that: 1) every case manager completes the baseline *Case Management Log*, and 2) every clinic staff member completes an *Abstinence Orientation Scale*.

Step 2: Evaluation of Baseline Data and Selecting Quality Improvement Goals:

The following questions help guide evaluation of current compliance with best-practice recommendations and selection of QI goals:

1) Are more than 80% of patients receiving greater than 60mg of methadone daily?
2) Are new and unstable patients receiving at least one counseling visit per week, and are stable patients receiving at least one counseling visit per month?

3) Does clinic staff have *Abstinence Orientation Scale* scores of less than 3?
4) Are new/unstable patients receiving urine screening at least once per week, and are stable patients receiving urine screening at least once per month?

Step 3: Prioritizing Quality Improvement Goals:

In the process of reviewing baseline information, a clinic may discover more than one practice area in need of improvement. In our intensive work with the OMS in nine Veterans Administration OAT clinics, we have found that if urine screen rates are inadequate, it is essential to increase these rates before focusing on other QI goals. While urine screening frequency is not one of the targeted practice areas, adequate frequency of urine screening is essential for assessing the appropriateness of a patient's dose and assessing when a patient is eligible for a contingency management privilege. Urine screen results are also a primary outcome for evaluating the impact of QI efforts. Assuming that urine screen frequency is sufficient, we have found that it is most efficient to focus initial QI goals on the areas of dose and counseling frequency. Very specific and concrete goals can be set in these areas and progress toward achieving these goals can be quite rapid, providing the clinic staff with a sense of accomplishment early on in the QI process. Assuming that both dose and counseling frequency have been assessed and determined to meet best-practice standards, clinics can select maintenance orientation or CM goals.

Step 4: Developing a Plan for Frequency of Ongoing Data Collection:

The OMS contains a convenient procedure for collecting ongoing case manager practice and outcome information. The baseline *Case Management Form* data can be entered into the OMS system and used to create monthly *Case Management Forms*. These monthly forms are pre-printed with the treatment plan information that the case managers submitted on their baseline forms. The case managers simply update any information that has changed since the baseline data collection and then fill in the columns for treatment outcomes. The frequency with which clinic leadership will require case managers to complete the *Case Management Forms* will depend on the clinic's QI goals. Because progress on the frequency of urine screens, dosing, and counseling can be quite rapid, clinics working on such goals should collect case management data monthly. Progress with goals related to maintenance orientation and CM tend to move at a slower pace. Clinics working on such goals can choose to collect case management data quarterly.

In addition to the monthly *Case Management Forms,* it is recommended that clinics working on a maintenance goal re-administer the *Abstinence Orientation Scale* every six months to monitor progress in this area.

Specific Interventions and Tools Available

Dose:

The OMS contains several useful tools for evaluating and increasing compliance with best-practice recommendations regarding dosing. Tools include the *Dose Review Form,* a *Dosing Algorithm* and *The Expert Panel Consensus Statement*, which were developed by a panel of experts in OAT specifically for inclusion in the OMS. (See Chapter 6, Materials and Forms, for copies of these tools.)

The *Case Management Log* feedback graphs will provide clinics with the percentage of patients who currently receive 60mg or more of methadone per day. However, this is actually a crude measure of dose compliance, as a significant minority of patients can be appropriately maintained on lower doses. The *Dose Review Form* provides a more precise assessment of compliance with best practice recommendations (See Chapter 6, Materials and Forms, for a copy of the *Dose Review Form* and instructions). Case managers can fill out a *Dose Review Form* for each patient receiving less than 60mg of methadone daily. The form lists the common reasons that patients are often maintained on lower doses (e.g., patient refuses recommended dose increase; patient is stable at this dose) as well as actions that can be taken to ensure that patients are receiving adequate dosing. Clinic leadership can request that case managers indicate on the *Dose Review Form* the reason for a client's low dose, and then choose an *action,* if it is appropriate. Cases with recommended action items should be reviewed by the treatment team within a month to ensure that appropriate actions have been taken. The dose review process can be repeated at specified intervals to document continued compliance with dosing recommendations (e.g., yearly) or to monitor progress toward increasing clinic performance on dosing recommendations (e.g., quarterly).

It is recommended that all clinics with less than 80% of patients receiving 60mg or more of methadone per day complete a dose review to assess the actual percentage of patients on guideline concordant doses. The results of the dose review will assist clinic leadership in evaluating whether or not there is significant room for improvement in this area. For clinics with less than 60% of patients receiving 60mg or more of methadone per day, it is highly recommended that in addition to an initial dose review, patient dosing be monitored monthly for at least six months. In our intensive work with nine VA OAT clinics, we found that a significant percentage of low-dose patients who were marked as "stable" on the *Dose Review Form,* submitted an opiate positive urine at some point in the next six months, indicating that their dose should be reevaluated. It is also important to use the monthly *Case Management Forms* to monitor patients who are on doses of greater than 60mg but are testing positive for illicit opiates. A dose increase should be one of the first strategies considered to address this issue.

For clinics that are working on QI goals related to dosing strategy, it will also be necessary to determine whether there are clinic policies in place that are contradictory to best-practice recommendations (e.g., routine policy of attempting to stabilize new patients on doses of less than 60mg; rigid dose ceiling). The *Dosing Algorithm* and *The Expert Panel Consensus Statement* provide a convenient source summarizing dosing recommendations that can be compared to current clinic practice.

Counseling:

If clinic leadership determines that increasing compliance with counseling frequency is an appropriate QI goal, then there are several factors to consider. First, is it the clearly stated policy of the clinic that new patients (i.e., enrolled less than one month) and unstable patients (i.e., those testing positive for illicit substances) should be seen by their case manager a minimum of once per week, and that stable patients should be seen by their case manager a minimum of once per month? If not, the first step toward meeting best-practice recommendations is to make policy changes supportive of these recommendations and to clearly communicate these expectations to the clinic staff and patients.

If counseling frequency consistent with recommended levels is already clinic policy, the next step would be to assess clinic caseloads. In general, a caseload of no more than 50 clients is considered to be reasonable for a full-time case manager. However, this number assumes that case managers have a case mix that includes stable, long-term patients as well as new and unstable patients who require significantly greater time to manage. If a case manager has predominately new and/or unstable patients, a caseload of 35 to 40 may be more reasonable. If caseloads are assessed to be too high, recruitment of additional staff would be ideal. If this is not possible, the clinic may have to limit the number of new intakes until the clinic census stabilizes at a level that can be adequately served by the existing staff.

If policies supporting counseling frequency recommendations are in place and clearly communicated to staff, and caseloads are assessed to be within a reasonable range, it may be a matter of educating staff about the importance of regular case management contact to client outcomes. The OMS includes a *Counseling Frequency Evidence Summary* (see Chapter 3: Quality Improvement and the Four OAT Practice Areas), which contains references specific to this issue. Relevant readings may be distributed to staff and discussed in team meetings. The monthly *Case Management Forms* can be used by the clinic leadership to monitor individual case managers progress toward meeting counseling expectations.

Maintenance Philosophy:

If compliance with best-practice recommendations regarding maintenance philosophy is selected as the clinic QI goal, the first issue that must be addressed is whether current clinic policies are contradictory to a maintenance philosophy. Policies that limit the duration of treatment or encourage clients to taper off methadone after a specified amount of time in treatment are in direct opposition to a maintenance philosophy (Caplehorn et al., 1998). According to a maintenance philosophy, clients should never be encouraged or pushed to taper off methadone. If a client requests a taper, clinic staff should discourage such a step unless the client has a significant period of stable functioning. Once a client is on a taper, screen results should be closely monitored for any signs of a return to illicit opioid use. If illicit opioid use occurs, the client should be encouraged to halt the taper and return to a dose at which they are able to maintain abstinence.

An additional policy that is contradictory to a maintenance philosophy is an overly strict regime against the use of illicit substances, using punitive measures such as administrative discharge to address continued use (Caplehorn, 1994). While there is no agreed upon “best-practice” regarding the amount of time that a client should be allowed to continue to receive methadone maintenance despite using illicit substances, research evidence clearly indicates that client outcomes are better in a methadone program than not (Magura & Rosenblum, 2001). Reevaluation of dose, increased counseling frequency, and CM (reviewed below) are other interventions that must be utilized prior to the consideration of administrative discharge. A lengthy trial (1 year +) of treatment before beginning an administrative discharge is highly recommended. The OMS includes a *Maintenance Orientation Evidence Summary* (see Chapter 3: Quality Improvement and the Four OAT Practice Areas) with attached references, which provide more detail on policies that support or contradict a maintenance philosophy.

Even if clinic policies are consistent with a maintenance philosophy, individual case managers in a clinic may still hold strong opinions that are contradictory to a maintenance philosophy. The best intervention in this case is to provide educational opportunities to clinic staff, which will provide them with information regarding the connection between long-term maintenance and client outcomes. Inviting expert speakers to provide educational presentations, providing staff with selected readings and using team development time to discuss these readings are interventions that can be helpful. The *Maintenance Orientation Evidence Summary* includes several relevant references. It is recommended that clinics working on maintenance orientation goals retest staff using the *Abstinence Orientation Scale* every six months to monitor progress in this area.

Contingency Management:

If a clinic selects increased compliance with CM recommendations for their QI goal, the OMS contains several useful tools that can assist clinic leadership in determining appropriate policy changes (see Chapter 3: Quality Improvement and the Four OAT Practice Areas). The CM section contains a S*ample Take-Home Privilege Policy,* which balances incorporation of best-practice recommendations for the use of CM with adherence to federal regulations governing patient access to take-home methadone doses. The plan details exactly what goals must be met for a client to gain each potential take-home dose, and exactly what behaviors will result in a loss of those privileges. Clinics can incorporate this plan as is into clinic policy or it can be used as a template, which can be tailored to meet the needs of a specific clinic. The most important aspects to retain if modifying the sample policy are to have a consistent plan detailing behavioral goals and privileges that can be earned, and to reward privileges for positive behavior as soon as possible (Petry, 2000). Also included in the OMS is a *Sample Contingency Management Contract,* which is to be used by a case manager and a patient to clarify the rules for gaining and losing take-home privileges. A clear understanding on the part of both patients and staff of what is required to earn take-home privileges is an essential component of an effective CM strategy.

Finally, this section contains a *Contingency Management Staff Worksheet,* which is designed to be used in a team meeting to structure a discussion regarding development of a consistent policy for awarding and revoking take-home privileges. In our experience with implementing QI in OAT clinics, we have found that CM recommendations can elicit strong opinions contrary to best-practice standards. Feedback from clinic leadership, with whom we have worked intensively, indicates the necessity of providing educational opportunities and group discussion opportunities for staff regarding these recommendations. The *Contingency Management Evidence Summary* lists several references that can be used to stimulate such discussion. To implement changes in take-home policies, clinic leadership must evaluate current policies, determine changes that they would like to incorporate, provide opportunities for education on CM principles, discuss proposed changes with staff, and then implement agreed upon changes.

Lessons Learned about Implementation of the OMS:

The most important lesson that we have learned from our experience with nine VA OAT clinics is that substantial prompting is necessary to create and sustain momentum for change. Our nine clinics were recruited to be a part of the Initiative, rather than by a volunteer approach. Therefore, participation in this intervention was often viewed as an additional burden for both clinic leadership and staff. Feedback from participating clinics indicated that continuing contact with the OpiATE Initiative staff was vital to establishing and maintaining momentum. Through monthly facilitation, conference, and research calls, clinic leaders were constantly reminded of their identified goals and the steps that they had committed to make in pursuit of their goals. Even with this high level of contact, circumstances arose that forced leadership and staff to divert their attention to other pressing issues, and progress with QI goals stagnated for a month or more. Feedback from participating clinics indicated that without continuing contact with the OpiATE Initiative staff, it would be unlikely that the clinic would return to a QI focus after such a period of stagnation.

For clinics that choose to implement the OMS independently, a high level of commitment to the process on the part of clinic leadership is necessary, as implementation will require staff time and clinic resources. It is essential that someone is designated to be responsible for maintaining the QI focus. It is preferable that this person volunteers for this role to ensure that she is motivated and excited about taking on this challenging task. This person's duties will include assuring that all necessary data is turned in by clinic staff; that feedback is provided in a timely manner; that baseline data is reviewed and QI goals selected; and that appropriate QI strategies are identified and implemented. This person should be a clinic leader, or have the full support of clinic leadership, so that she will have the power to request necessary materials from other staff members and instruct them on policy changes. It is preferable that an arrangement be established which would free some portion of the responsible person's time to devote to this process.

In summary, QI in an intervention that is as complex as OAT is difficult to undertake. We have attempted to provide a system that allows for fast and easy assessment of clinic practices and outcomes, which allows tailoring of the QI process to the individual clinic's

needs, and which provides educational materials and QI tools to assist in making the process as simple as possible. Feedback from the nine clinics that have implemented this system to date assures us that the procedures are simple and well worth the quality of feedback received. Outcome data has shown rapid improvement in compliance with dosing recommendations, as well as improvements in program philosophy and implementation of CM principles. Clinics that undertake this challenging process will have the evidence to demonstrate a positive change in clinic practices and the knowledge that they are providing the best possible care to a group of patients with very complicated and difficult issues.

Selected References

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